14. Payment Review, Fraud, and Abuse

An adult care home enrolled with the Division of Medical Assistance (DMA) as a provider of Adult Care Home Personal Care (ACH/PC) and Non-Emergency Medically Necessary Transportation (NEMNT) shares responsibility with DMA in assuring that Medicaid funds are used properly.

14.1 The Purpose of Prevention and Detection Efforts

DMA has policies and procedures to prevent and detect abuse, over utilization, and fraudulent practices by providers, recipients, or others involved with Medicaid. This is part of DMA's efforts to ensure the most effective use of Medicaid funds. The policies and procedures provide for due process in investigations, including applicable appeal and fair hearing rights. Within DMA, the Program Integrity Section is primarily responsible for detecting misuse of Medicaid funds.

14.2 Provider Education

To assist your facility in complying with Medicaid's requirements, DMA supplies you with a provider manual containing information on participation, coverage, limitations and reimbursement. DMA and EDS update this information through monthly Medicaid Bulletins. They also offer provider seminars throughout the state. Each have staff to provide guidance and assistance, and help is available by phone or mail. The address and phone numbers of key contacts are listed in Appendix B.

14.3 Reporting Fraud, Abuse, and Misuse of Funds

If you suspect misuse or abuse of the Medicaid program, contact DMA's Program Integrity Section at the number listed in Appendix B.

Note: Concerns about quality of care, qualifications of caregivers, and other issues related to a provider's licensure or certification should also be reported to the appropriate licensing or certifying authority (see Appendix B).

14.4 Prepayment Review of Claims

The claims processing system does a number of checks before your claim is paid. It will look at:

- A resident's eligibility on the date of service;
- Any required prior approval;
- Third party liability;
- Allowable charges and amounts of service;
- Possible duplicate services; and
- Other factors affecting payment.

Only claims that pass the various checks in the claims system will be paid. As a provider, you also share the responsibility of verifying that payments you receive are accurate. See Section 12 for information on tracking claims.

14.5 Recipient Explanation of Medicaid Benefits (REOMB)

Another means of detecting payment problems is the Recipient Explanation of Medicaid Benefits (REOMB). DMA sends the REOMB to randomly selected recipients of Medicaid services. It gives information on the Medicaid services paid on behalf of the recipient. The form includes the provider's name, the date(s) of services, and the payment amount(s). Instructions on the form tell the recipient what to do if any of the listed services were billed directly to him or were not actually provided.

14.6 Post-Payment Reviews in General

DMA and other agencies review the expenditure of Medicaid funds and the provision of Medicaid services. Upon request, your facility must furnish financial, medical, and other records related to service delivery and payment to DMA and its agents, the Department of Health and Human Services and its agents, and the State Attorney General's Medicaid Investigations Unit.

When discrepancies are discovered, the action depends on the apparent cause, extent and severity of the problem. Actions may include:

- An educational letter to the provider stating the problem and giving guidance for corrective action.
- Recoupment of payments.
- Termination of the participation agreement.
- Referral for prosecution.

All notifications to providers about adverse actions contain information related to applicable rights for reconsiderations, appeals, and hearing.

14.7 Program Integrity (PI) Reviews

Within DMA, the Program Integrity (PI) Section conducts reviews to:

- Identify problem areas in compliance with medical or billing policy;
- Educate providers and recipients when problems are found requiring corrective action;
- Identify needs for policy and procedure definitions or clarification.
- Identify providers and recipients who appear to be abusing or defrauding Medicaid;
- Identify and collect provider and recipient overpayments; and
- Ensure that recipients' rights and safety are protected.

PI handles these tasks and cooperates with the State Medicaid Investigations Unit of the Attorney General and the fraud and abuse staff of the county departments of social services. PI operates under federal and state laws and regulations which are both stringent and comprehensive. The State rules are in the State Administrative Code 10 NCAC 26G, and the Federal regulations are found in 42 CFR 455. Information regarding requirements resulting from these laws and rules are conveyed to all providers through provider manuals and Medicaid Bulletins.

14.7.1 Determining Areas for PI Review

PI reviews are initiated for a variety of reasons. The following are some common examples of referrals (this list is not all inclusive):

- Random sample reviews.
- Recipients or family members complain about a provider.
- Other providers, other state agencies, county agencies or other DMA sections provide reports or complaints.
- Quarterly Surveillance and Utilization Review Subsystem (SURS) reports of the Medicaid Management Information System (MMIS) identifies providers and recipients whose patterns of practice and use of services fall outside of the norm for their peer groups.
- Special computer runs based on reports from referrals to look at specific issues, procedure codes, and possible duplications of services identify a need for review. This can also include high dollar providers or providers not billing Medicare.
- Identification of a problem with one provider indicates a need to review other providers of the same service in regard to the same potential problem. This type of review focuses on the identified problem rather than all potential problems.
- Areas that EDS identifies as questionable during claims processing.

14.7.2 Your Responsibilities Relating to a PI Review

Once you are notified that PI is initiating a review, you can assist the process to ensure the review will be both positive and educational.

- PI conducts reviews by mail and in person. Visits to your adult care home and residents may be unannounced. (An unannounced visit does not mean your facility is suspected of wrongdoing. It is a routine procedure.)
- Provide all requested records to substantiate all services and billings to Medicaid. If the requested records are not submitted for review, then PI will recoup the payments in full since it cannot establish that the services billed were appropriate or provided.

  Remember: Keep records for five years according to your provider participation agreement.
- If you get a recoupment letter, review the information and details in the letter and recoupment chart.
  - If you want a Reconsideration Review, complete the request form that is enclosed with the letter. Send the form to the DMA's Hearing Officer at the address on the form. Indicate on the form if you want a Personal Hearing or a Paper Review. Personal Hearings are held in Raleigh with the Hearing Unit assigning the date, time, and place. If you would like a Paper Review, you must submit any additional relevant documentation to the Hearing Unit.

Caution: Pay close attention to the timeframes and procedures for requesting a Reconsideration Review.

- If you agree that an error and overpayment was made, then use the other form enclosed with the letter to indicate the preferred method for re-payment (check enclosed or withhold from future Medicaid payments). Return the form to Accounts Receivable at the address on the form and enclose the check if you select that option of repayment.

  Caution: Do NOT send any checks to EDS for PI reviews as this could cause duplicate recoupment.

- If you need help to assure that the error does not happen again, call EDS and request a visit. If you call EDS or DMA to get clarification of policy or procedures, record the date, who you talked to, the issue discussed, and the guidance provided.

  Remember: Always follow written policy and procedures. Keep up with the current Medicaid Bulletin information. Make sure that all staff involved with providing and billing Medicaid services have access to this manual and the bulletins. Take advantage of the provider training seminars offered by DMA and EDS.